North Simcoe Muskoka **LHIN**
RLISS de Simcoe Nord Muskoka

Healthy People.
Excellent Care.
One System.

Annual Report 2011-2012

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

North Simcoe Muskoka
Local Health Integration Network
Annual Report 2011-2012
Table of Contents

Message from the Board Chair and Chief Executive Officer	1
Members of the Board of Directors	3
Welcome to the North Simcoe Muskoka LHIN	4
North Simcoe Muskoka Health Profile	6
Local Health System Integration Act, 2006	6
Integrated Health Service Plan 2010-2013	7
Integration	13
Information & Communications Technology / eHealth	14
Engaging the Community	15
Ministry/LHIN Performance Agreement – Performance Indicators	16
North Simcoe Muskoka LHIN Operations	21
Financial Statements	

Message from the LHIN Chair and Chief Executive Officer

Robert Morton
Chair

Bernie Blais
Chief Executive Officer

On behalf of the Board and staff it is our pleasure to present highlights of activities that have occurred in North Simcoe Muskoka during fiscal year 2011-2012 - a year of implementation, change and collaboration.

Similar to last year, our integrated health system design project, *Care Connections – Partnering for Healthy Communities,* consumed much of our time. However, it was the implementation of initiatives within the six clinical areas of focus along with the six system enablers to support that implementation moving forward, which kept us busy.

We hosted our third forum where LHIN funded and non-funded health service providers and others discussed next steps in our *Care Connections* journey – achieving **one** system of health care for North Simcoe Muskoka. A system that places the individual at the centre of that care.

We would like to recognize the members of North Simcoe Muskoka LHIN's Leadership Council for their continued oversight role as the steering committee responsible for the implementation of the *Care Connections* project priorities.

In recognizing the Leadership Council we want to acknowledge the hours of work that all our providers have dedicated to the project and in particular those organizations leading Coordinating Councils. Thank you everyone – you're commitment to a system of care designed for the needs of North Simcoe Muskoka residents is to be commended.

In February, the Board of Directors was presented with the final draft Mission, Vision and Values document developed by LHIN staff. We were moved by their passion, dedication and enthusiasm. . The Board unanimously approved the following statements:

Vision: Healthy people. Excellent care. One system.

Mission: Together ... Achieving Better Health, Better Care, Better Value

Values: Be Real. Be Revolutionary. Be Courageous.

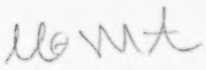
In 2011-2012 our Board saw a significant change with the departure of Erica Curtis, Lynda Coad and Ruben Rosen. Erica had been on the board for one term and chose not to apply for a second term. Lynda served two terms and also acted as the Chair of the Board's Health Services Committee. We thank Lynda and Erica for their commitment to North Simcoe Muskoka.

Ruben Rosen was the inaugural Chair of North Simcoe Muskoka Local Health Integration Network, having been appointed in June 2005.

Mr. Rosen oversaw the development and implementation of the first Integrated Health

Service Plan and the development of the 10-year *Care Connections – Partnering for Healthy Communities* integrated health system design for North Simcoe Muskoka.

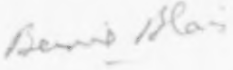
As the LHIN Chair, I believe North Simcoe Muskoka has an opportunity to be a provincial leader in health care delivery. In the news release that announced my appointment I said "This is a critical time for our health care system. Through working in partnership with the LHIN's health service providers we know that we can improve the health care experience for the residents of North Simcoe Muskoka." The work of the LHIN over the past year has only served to confirm this statement.



Robert Morton, Chair

By June 2011 the North Simcoe Muskoka LHIN Board was operating with a full complement of directors. Welcome to new directors Jake Arnold, Peter Preager, Margaret Redmond and Ron Stevens – we look forward to their contributions to our governance and system responsibilities.

Bernie and I would like to thank the LHIN Board and staff, our LHIN funded and non-funded health service providers and our communities for their ongoing commitment and support, as we continue to work together to achieve our vision of *Healthy people. Excellent care. One system.*



Bernie Blais, Chief Executive Officer

Members of the Board of Directors

Robert Morton, Chair (2011-2014)

Committee Membership:
- Finance & Audit
- Governance
- Health Services

Anne Gagné, Vice-Chair (2007-2013)

Committee Membership:
- Finance & Audit
- Governance (C)

Rick Antaya, Director (2010- 2012)

Committee Membership:
- Governance
- Health Services

Jake Arnold, Director (2011-2013)

Committee Membership:
- Health Services

Peter Brown, Director (2010-2012)

Committee Membership:
- Governance
- Health Services

Don Mitchell, Director (2010-2012)

Committee Membership:
- Finance & Audit (C)

Peter Preager, Director (2011-2014)

Committee Membership:
- Finance & Audit
- Governance

Margaret Redmond, Director (2011-2013)

Committee Membership:
- Health Services (C)

Ron Stevens, Director (2011-2014)

Committee Membership:
- Finance & Audit

Welcome to the North Simcoe Muskoka LHIN

Introduction

The **North Simcoe Muskoka Local Health Integration Network** (LHIN) is one of 14 regional organizations created by the Province of Ontario to improve the way health services are planned and delivered at the local level.

The North Simcoe Muskoka LHIN is responsible for planning, coordinating and funding health services to meet the specific needs of our communities in order to keep us healthier, have better access to health care services and reduce wait times.

While the LHIN does not directly provide health care services, we work with many agencies involved in providing care across the continuum of health including health service providers, social and community care providers, along with municipalities and members of the public. Together with our health service partners we establish priorities and plans for health services delivered in North Simcoe Muskoka. The LHIN also provides system leadership, spurs change and fosters collaboration among all health system partners, including health service and primary care providers and public health professionals.

The North Simcoe Muskoka LHIN funds 77 health service providers which spans the entire health care continuum in North Simcoe Muskoka. In 2011/2012, we allocated approximately $781 million to the following local health system organizations and/or specific programs:

- 7 Hospitals
- 1 Community Care Access Centre (CCAC)
- 26 Long-Term Care Homes (LTC)
- 3 Community Health Centers (CHC)
- 31 Community Support Service Organizations (CSS, ABI & ALSSH)
- 9 Community Mental Health Agencies (MH & Addictions)

North Simcoe Muskoka LHIN Population Profile

North Simcoe Muskoka is growing and aging faster than the province as a whole.

- From 2001 to 2009, the population in the NSM LHIN catchment area (as derived from population estimates prepared by the Ontario Ministry of Finance) rose by 15.1%, while the net increase to the provincial population rose by a more modest 9.8%, during the same time period. By 2020 the overall population is expected to grow by approximately 35.2% in North Simcoe Muskoka, as compared to 2001 census population figures. This compares significantly to the Ontario population estimates for the same time period, in which overall growth is expected to reach 25.2%, a full 10% less than what NSM is expected to experience.
- In 2011, seniors aged 65 + in the NSM LHIN accounted for 14.1% of the total population, which mirrors that of the province. By 2020, the NSM LHIN will have the fifth greatest growth rate of seniors as compared to all other LHINs in the province This growth of seniors will place more demands on health care services in the Region.
- The area's base population is less diverse than other parts of Ontario. It has relatively lower numbers of immigrants and visible minorities. It does have a higher share of Aboriginal Peoples – 3.3% versus 1.4% province-wide. French is the mother tongue for about 3% of this region versus 4.4% province-wide.

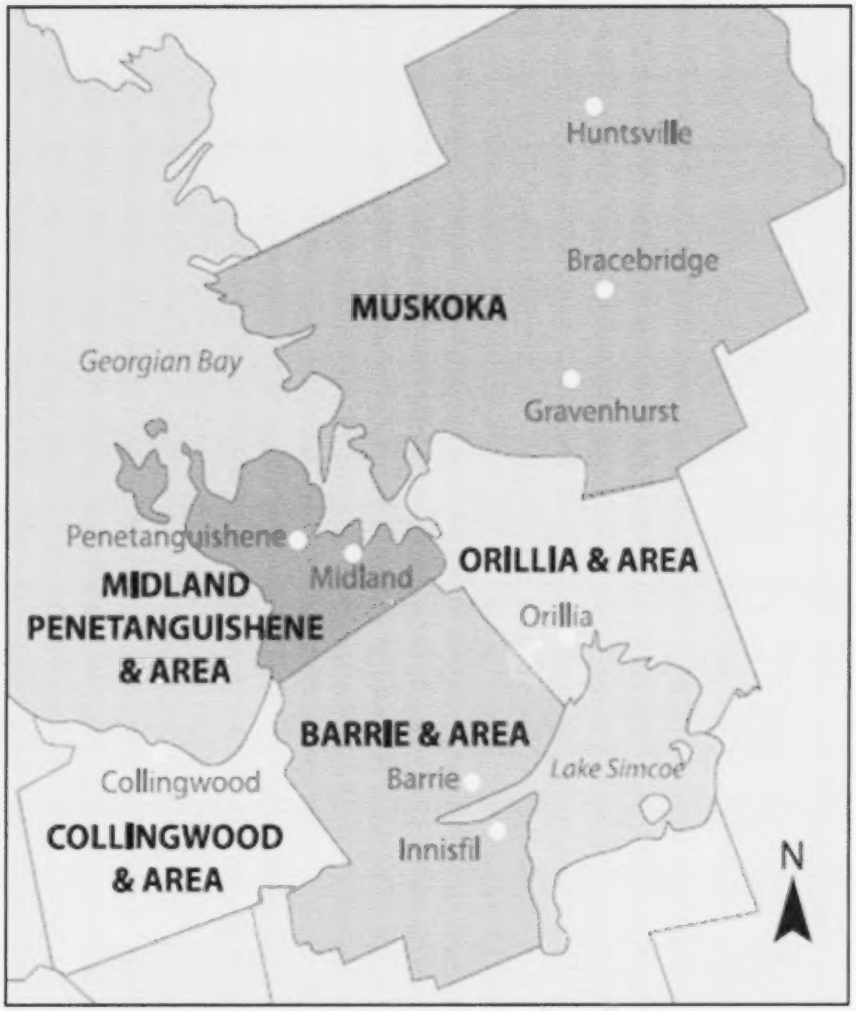


Figure 1: Map of NSM LHIN with 5 Geographic Areas

While healthcare needs are planned and provided on a LHIN-wide level, there is recognition that due to differing population structures across the five geographic planning areas, there is need for geographic-specific health care planning to effectively target the different segments of the population.

North Simcoe Muskoka Health Profile

The North Simcoe Muskoka LHIN continues to be challenged by the health status of our residents. Poorer health status drives health care utilization and costs.

According to the Statistics Canada Health Profile February 2011, 56% of the North Simcoe Muskoka population is obese or overweight. To a lesser degree, Ontario also witnessed an increase in overweight and obese population at 51%. The NSM smoking rate has risen to 26%, while the provincial average decreased to 19%.

Heavy alcohol consumption is 18% compared to 15.6% provincially. Fruit and vegetable consumption rose to 44% at par with Ontario consumption level. Fruit and vegetable consumption among NSM LHIN women was 51% compared to male consumption of 38%.

In North Simcoe Muskoka, many chronic conditions such as arthritis and hypertension have increased and remain higher than the provincial level. 21% of North Simcoe Muskoka's population has been diagnosed with high blood pressure compared to 17% for Ontario.

In North Simcoe Muskoka, the rate of death from all causes per 100,000 population is 579, higher than 522 in Ontario. Rates of death from all cancers per 100,000 population is higher at 176 compared to the provincial average of 159. Death resulting from lung cancer and prostate cancer are at higher levels than the province.

Rate of injury hospitalization per 100,000 population is 505, higher than the provincial average of 420. The proportion of women delivering babies in acute care hospitals by caesarean section is 31%, higher than the 29% provincial average. Hospitalized hip fractures remain higher for the 65+ population in North Simcoe Muskoka at 482 events per 100,000, higher than 451 events provincially. The rate of hospitalization for the older female population of North Simcoe Muskoka is twice that of the male population at a ratio of 611 fractures for females to 305 fractures for males, reflecting the higher elderly female demographics in North Simcoe Muskoka.

Local Health System Integration Act, 2006

The Local Health System Integration Act, 2006 (LHSIA) outlines expectations for an end state, mature system of planning and health care integration in Ontario. The LHIN's Integrated Health Service Plan (IHSP) is the foundational three-year strategic plan that sets out the vision, priorities, strategies and outcomes for how the local health system will work to achieve these expectations.

LHSIA articulates essential principles to guide the LHINs' implementation of the community engagement, planning and integration functions, all of which support the execution of the Integrated Health Service Plan. These principles include:

- Community Engagement
- Cooperation, Coordination and Integration
- Equity and Diversity
- Accountability and Transparency

Integrated Health Service Plan (IHSP) 2010-2013

"Working Together to Achieve Better Health, Better Care, Better Value"

Building upon the findings from our first Integrated Health Service Plan, the North Simcoe Muskoka LHIN's second three-year plan became effective on April 1, 2010 and identified the following three priorities:

1. Improve access to appropriate care, beginning with the emergency room and alternate level of care setting in the community or home;
2. Improve chronic disease management beginning with access to integrated diabetes care; and,
3. Create an integrated design for the future health system in NSM LHIN.

Strategic Direction 1

Improve access to appropriate care, beginning with the emergency room and alternate level of care setting in the community or home.

The North Simcoe Muskoka LHIN provides a large number of services designed to improve Emergency Room (ER) wait-times and reduce the number and percent of Alternate Level of Care (ALC) patient days. These LHIN funded services are delivered through hospitals, the Community Care Access Centre (CCAC), long-term care homes and community support agencies.

There are currently six ERs in the North Simcoe Muskoka LHIN – Collingwood General & Marine Hospital (CGMH), Georgian Bay General Hospital (GBGH), Muskoka Algonquin Healthcare (MAHC) – Huntsville and Bracebridge sites, Orillia Soldiers' Memorial Hospital (OSMH), and Royal Victoria Regional Health Centre (RVH).

Alternate Level of Care days are captured and monitored weekly across all North Simcoe Muskoka hospitals, including Waypoint Centre for Mental Health Care.

Emergency Room / Alternate Level of Care - Status

- ***Rapidly aging population.*** In 2011, the North Simcoe Muskoka LHIN had the fifth largest proportion of seniors aged 65 + in the province. The Ministry of Finance projects the proportion of persons aged 75 + to almost double by 2036, representing more than 14% of the total population.
- ***Diverse geography and population distribution.*** The population distribution within the broad geographic area of North Simcoe Muskoka impacts the provision of service delivery. For example, seniors, the highest user of health care resources, often reside in rural settings. With growing retirement communities in Collingwood, Wasaga Beach, Midland, Penetanguishene and Muskoka, the challenges in delivering health care services in rural settings will increase.
- ***Chronic disease risk factors and incidence of chronic disease.*** NSM LHIN worked with our health service providers to address the prevention, self-management, readiness for home services and monitoring of chronic diseases. The key to success in managing chronic diseases and providing the care our residents need is accessibility.
- ***Gaps in system infrastructure which limit options available to area residents.*** In the first quarter of 2011-12, North Simcoe Muskoka had the third highest rate of unscheduled ER visits in the province, as compared to its counterparts. Some of this can be attributed to the needs of the population and gaps in system infrastructure. Examples of existing gaps include a limited immediate

response infrastructure (i.e. urgent care centres), poor supportive housing stock, transportation system limitations and gaps in specialized services (i.e. specialized geriatric services, mental health and palliative care). Through the ER/ALC Strategy and innovative programming, the LHIN is addressing some of these gaps and ongoing planning and resource investment are required.

Emergency Room / Alternate Level of Care – Performance Highlights

- Compared to the previous fiscal year, there was an increase of 4.9% in the number of unscheduled visits to the ER across our LHIN in 2011/12.
- By March 2012, nine out of ten patients in the emergency room were waiting 1.5 hours less than the provincial result.
- During 2011/12, almost 92% of non-admitted high acuity patients were treated within 8 hours in the emergency room, a slight improvement over the previous fiscal year.
- Patients continue to be satisfied with the care they are receiving in the ER. In Q3 2011, the percentage of patients with an overall positive satisfaction rating in the ER increased to 88%, an improvement of 4% from the baseline.
- At the beginning of 2011/12, 9 out of 10 Alternate Level of Care (ALC) cases (90th percentile) had a length of stay of less than 39 days. During 2011/12, the 90th percentile length of stay increased to 45 days in the 3rd quarter but decreased again in Q4 to 41 days.
- Average ALC length of stay also increased by slightly more than 1 day (15 days in the first quarter of 2011/12 to just over 16 days by the end of 2011/12).
- NSM LHIN saw a significant surge in its percentage of ALC days in Q3 with an increase in both the raw number of ALC days and the total number of patient days. The main reason for the increase was due to a high number of patients being discharged after remaining ALC for a significantly long stay (>30 days as ALC). These patients accounted for an increase of just over 2,300 ALC days.

Building Capacity & Improving Performance within the ER - Status

All hospitals in North Simcoe Muskoka have actively engaged in strategies to improve ER performance. Pay for Results and the Emergency Department Process Improvement Program (ED PIP) were significant enablers of this improvement in all five acute care NSM hospitals.

Collingwood General and Marine Hospital, Muskoka Algonquin Healthcare, Royal Victoria Regional Health Centre and Georgian Bay General Hospital continue to benefit from LEAN process improvements that optimize patient flow. Four ERs in the region have implemented Clinical Decision Units, two ERs have established "See & Treat" areas and several of the hospitals have worked with physicians to change schedules and practice patterns to improve the Time to Physician Initial Assessment.

This past year, the Huntsville site of Muskoka Algonquin Healthcare implemented a Physician Assistant-led fast track area to improve the flow of lower acuity patients. Organizations have implemented discharge lounges, bullet rounds, white boards and numerous other initiatives across the organization to improve patient flow.

Building Capacity & Improving Performance within the ER – Performance Highlights

Looking back over the last year, the North Simcoe Muskoka LHIN continued to perform well in ER wait times with overall performance ranking far above average, in one fiscal quarter ranking best in the province. Success can be attributed to aligning funding and action with the ER/ALC Strategy and the commitment of health service providers to be accountable for improved targets. Over the same period, North Simcoe Muskoka faced ongoing pressures related to ALC performance. As we look forward to 2012/13, we anticipate better success and outcomes as new initiatives targeting ALC move from planning to implementation of core sustainable system change and realignment of resources.

Funding over the last several years has targeted high-risk ER users to create alternate options for care. The newly funded LHIN-wide Palliative Care Resource Team supports health service providers and patients in managing palliative care issues. Nurse Led Long-Term Care Outreach teams link nurse practitioners with frail seniors in long-term care for the on-site management of issues that historically have resulted in an ER transfer.

The Integrated Regional Falls Program (IRFP) includes services from prevention to specialized geriatric services with the model providing a foundation for much of the provincial planning related to falls prevention. The IRFP, while increasing its client roster by more than twice the anticipated volume, has seen an 86% reduction in ER visits related to falls and an 89% reduction in the number of falls. Not surprisingly, results of the most recent IRFP client satisfaction survey reflect a highly favourable 97% overall satisfaction rate with the program.

Options for primary care have been expanded in North Simcoe Muskoka. Two new Community Health Centres began operation and two new Nurse Practitioner–Led Clinics were opened. A third clinic will begin operation in 2012/13. In January 2012 Algonquin Grace, a five bed residential hospice in Huntsville, was opened to serve Muskoka residents. In January 2012, planning also began for the implementation of a Seniors Health Team to serve frail seniors in the Muskoka region.

Improved Bed Utilization – Status & Performance Highlights

Numerous initiatives were funded in order to improve the flow of patients and reduce Alternate Level of Care days. In addition to continued funding for 26 interim long-term care beds, funding was provided to complete the North Simcoe Muskoka Palliative Care Resource Team and establish a Seniors' Health Team in Muskoka. The latter two initiatives are designed to support early discharge and the management of individuals in the community.

Significant investment was made to support the implementation of a Home First philosophy. This investment included funding to the CCAC, as well as LHIN support in the planning of the CCAC expanded role, including shifting lower needs CCAC clients to the Community Support Sector.

Senior Friendly Hospital Strategy planning this past year was fast-tracked by the leadership of a Senior Friendly Hospital Strategy Coordinator. With this support, each hospital is working to implement programs to reduce functional decline in hospitalized seniors.

Complex Continuing Care (CCC) continued to be a major focus for North Simcoe Muskoka over the past year with a LHIN-wide approach to CCC operations and care well underway under the leadership of a Complex Continuing Care System Coordinator. CCC Committees developed policies and procedures to achieve a standardized approach to care and a bed registry was implemented which has seen a reduction in the volume of ALC and other needs patients in CCC beds.

In 2011, significant leadership was provided provincially and locally in Behavioural Support System planning. With plans well underway, an integrated system of supports for individuals living with behaviours has been implemented. Through the re-alignment of existing resources and the addition of new, individuals and caregivers will receive better care and more individuals will be supported in their home environments.

In May 2011, LHIN-wide Alternate Level of Care (ALC) Bullet Rounds were established. These rounds provide an opportunity for front line and leadership representatives from across sectors to have weekly discussions of the ALC current state, discuss trends and issues, explore opportunities for collaboration and collective problem-solving and leverage system capacity. In recognition of the ongoing challenge to ensure patients are in the right bed, at the right time, in the right place, at the right cost, an ALC Steering Committee was established. Within two weeks of being created this Committee developed an Action Plan to guide 2011-2012 work. This Action Plan was developed through various working group sessions and work completed by the previous ER/ALC Steering Committee. It also reflects findings from the provincial report of Dr. David Walker entitled, *Caring for Our Aging Population and Addressing Alternate Level of Care.*

Strategic Direction 2
Improve chronic disease management beginning with access to integrated diabetes care.

As a support to our Integrated Health Service Plan 2010-13, the Ontario Diabetes Strategy (ODS) and the health of North Simcoe Muskoka residents living with diabetes, the NSM LHIN aims to achieve Better Health, Better Care, Better Value through integrated and collaborative partnerships which:

1. Enhance the delivery of diabetes care in North Simcoe Muskoka; and
2. Enhance the management and quality of diabetes care in the North Simcoe Muskoka.

Chronic Disease Prevention and Management (CDPM) was identified as a key area of focus as part of the 10-year *Care Connections: Partnering for Healthy Communities* integrated health system design. While the initial focus is on diabetes self-management and care, the LHIN and our partners are committed to the advancement of a LHIN-wide model for chronic disease prevention and management, aligning with LHIN and provincial initiatives.

Key Deliverables and Milestones

The implementation of NSM LHIN diabetes indicators, borrowed from the work of the Baseline Diabetes Dataset Initiative (BDDI), include indicators which address best practice guideline targets for HbA1C (blood test), Low-density Lipids Data (LDL) and Retinal Eye Exams. The intent was to also prepare our region for the future implementation of the electronic Diabetes Registry.

- Strategic alignment and collaboration with the Diabetes Regional Coordination Centre (DRCC) will

continue to ensure we are achieving our overall goal of a LHIN-wide model for CDPM with a focus on diabetes.

- Diabetes Self-Management: The South Georgian Bay Community Health Centre (SGBCHC) was able to implement a diabetes self-management program with the funding provided through the Ontario Diabetes Strategy and surpass deliverables. In all cases, SGBCHC was able to surpass or achieve the targets.
- Over the next two years the Chronic Disease Prevention and Management (CDPM) Steering Committee will develop CDPM Care Pathways and a method of system navigation for health service providers and patients/clients.
- An inventory of North Simcoe Muskoka diabetes programs and services was completed by the Diabetes Regional Coordination Centre.
- A Diabetes Education Day was hosted by the Diabetes Regional Coordination Centre which focused on new and innovative strategies to manage and prevent diabetes including metabolic syndrome for those with mental health issues and bariatric surgery.
- Surpassed targets for diabetes self-management training.

Strategic Direction 3

Create an integrated design for the future health system in NSM LHIN

Care Connections – Partnering for Healthy Communities

Care Connections **Vision**

Healthy people. Excellent care. One system.

A healthy population supported by the North Simcoe Muskoka health system - a respectful, accessible, and coordinated collection of health services that, when needed, offers the necessary care and works with people to help them manage their own health.

A health system optimizing the use of our collective resources to promote a healthy and supportive environment, taking care of people when they become ill and helping them maintain better health through all stages of life.

Background

The Integrated Health System Design (IHSD), branded as *Care Connections – Partnering for Healthy Communities*, is a 10-year strategic plan that outlines steps to be taken to collectively realize this vision.

Over 350 health care and other professionals contributed in excess of 20,000 hours of their time, engaged in facilitated working sessions using "best available" data/information, leading practices and expertise within their particular area of care in Ontario and other jurisdictions. Informed by the residents of North Simcoe Muskoka and the results of nine working groups of front-line stakeholders, the plan includes models of care and service delivery approaches with over 500 associated short, medium and long-term recommendations, and a transformation model to guide implementation. These initiatives include:

- improving the health of the population through increased access and quality of care
- enhancing the use of collective resources through streamlined processes and collaboration; and
- producing system-wide value for money across several sectors of care; *better health, better care and better value.*

The plan provides for a system of coordinated health and health care services that include provider, self-care and provider/self-care co-managed options. These options are aimed at keeping people healthy and taking care of them when they become ill. The plan also provides for a supportive environment to help create a healthier population, able to maintain better health, through all stages of life.

While these collective initiatives take place over a 10 year period (2010 – 2020), the NSM LHIN Board approved implementation planning in twelve 'areas of focus' in February 2011. Stakeholders actively involved include 77 LHIN funded health service providers (HSPs), more than 70 non-LHIN funded organizations representing all sectors across the continuum of care and the public representing 'persons with lived experience'. Several organizations whose primary mandate relates to other determinants of health have been included to ensure a fully integrated health system design will be achieved.

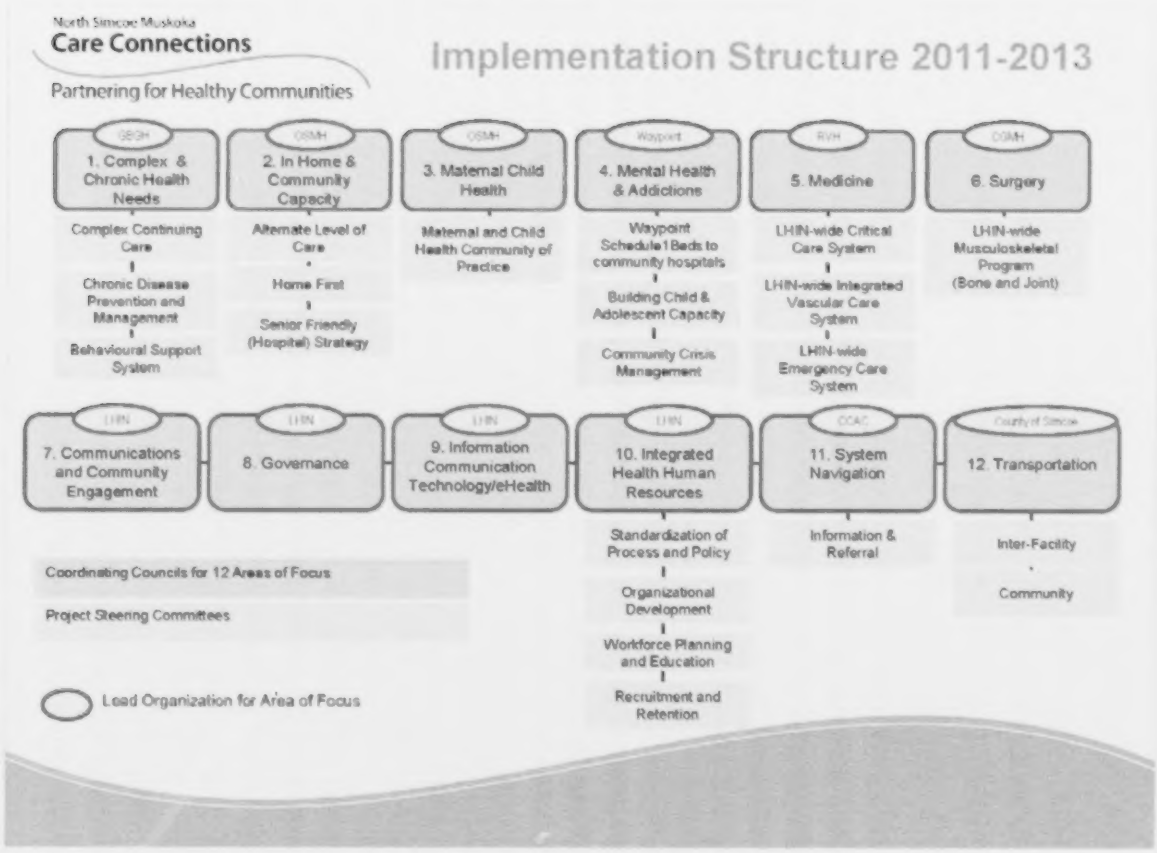
The *Care Connections – Partnering for Healthy Communities* plan sets out:

- How individuals and their support systems (partners, families, communities in which they live) access services and navigate through an integrated system to receive timely services as close to home as possible.
- How people and providers access information (education, consultation and information sharing).
- How people will receive care including entry points for monitoring and maintaining health, screening, and intervention through standardized coordinated models of care.
- How care will be organized across the LHIN and coordinated with services throughout the province, when necessary. Based on the level of specialization, services will either be offered in each of the five local geographic areas or clustered into a LHIN-wide service delivery model. All services requiring a level of specialization beyond the capacities of a LHIN-wide program or service will be referred to partner organizations across the province.

Shared Accountability

To achieve the vision and sustain an integrated health system in North Simcoe Muskoka, the health system resources will begin to shift and along with that will be the expectation for the accountability to change. The lead organizations have demonstrated a commitment to change and provider Boards have currently signed accountability agreements and passed board motions to implement and share accountability for the results of these areas of focus. The lead organizations are working together as a system and are accountable for the deliverables within their specific area of focus.

Health service provider boards are working with the LHIN Board to develop new mechanisms for governing an integrated health system.



Integration

North Simcoe Muskoka LHIN continues to focus on integration as a key driver for health system transformation. We have brought all sectors together through our LHIN Leadership Council to create health care solutions for the LHIN as well as for our local communities. *Care Connections*, our largest facilitated integration, has mobilized all sectors to work together and is on the cusp of implementing a LHIN-wide transformation of our NSM health care system.

Integration Activity

In 2011-2012 one voluntary integration was implemented through the Local Health System Integration Act (LHSIA) legislation. Thirty-one Schedule 1 adult acute mental health beds were transferred from Waypoint Centre for Mental Health Care in Penetanguishene to Georgian Bay General Hospital (Midland – 20 beds) and Royal Victoria Regional Health Centre (Barrie – 11 beds).

Information and Communications Technology / eHealth

The Hospital Report Manager (HRM) pilot was completed in 2011. HRM is an automated download for hospital reports (such as medical records, diagnostic imaging, cardio respiratory, lab, pathology, microbiology, blood bank) to Electronic Medical Records (EMR) at Family Health Team (FHT) offices.

Royal Victoria Regional Health Centre, Georgian Bay General Hospital and Collingwood General and Marine Hospital and their associated FHTs implemented HRM as part of the provincial pilot in 2011. The pilot has been an overwhelming success.

- *Improved Delivery Time*
  Prior to implementation delivery of paper reports from hospitals to their associated Family Health Team for input into electronic medical records took up to 12 days.
  Post implementation now results in reports being electronically transmitted directly to the FHT within 30 minutes of completion.
- *Productivity Improvement*
  Physicians now spend 2 hours per day scanning, filing and inputting their reports into EMRs compared to 4.5 hours prior to implementation.
- *Hospital Cost Savings*
  Printing, paper and ink budgets for hospital Health Records departments is planned to be reduced by 50%.

The NSM LHIN recently completed the Complex Continuing Care (CCC) and Orthopaedic Bed/Patient Registry projects. These tools build upon the existing mental health bed registry and meet the needs of Complex Continuing Care and orthopaedics. All seven NSM hospitals are now utilizing the registry to enhance tracking, referrals and data collection regionally.

The 'ufirst' project extends child and adolescent outpatient psychiatry referral services to approximately 37 family physicians in the Georgian Bay Family Health Team. The application allows for e-referrals from physicians through their own electronic medical record or family health team conveying specific patient care information. The tool supports timely clinical intervention when and where needed. 'ufirst' provides for an electronic notification to a child psychiatrist of a client in crisis.

The Telemedicine Adoption initiative continues to broaden the implementation of telehealth and telemedicine capabilities across the LHIN. As a result of the initiative, funding for ten additional Ontario Telemedicine Network (OTN) staff was approved in November 2011.

The provincial Integrated Assessment Record (IAR) being deployed by Community Care Information Management (CCIM) was a major focus in 2011. The NSM LHIN took part in the initial Doorways pilot project which concluded June 30, 2011. This pilot was the first of its kind in Ontario for the sharing of Personal Health Assessment Information across organizations and sectors. It involved 4 LHINs and 22 participating Community and In-Patient Mental Health service providers.

The e-Prescribing initiative continues to provide benefits to physicians, pharmacists and clients. This is a collaboration between the Georgian Bay Family Health Team, all local pharmacies, the NSM LHIN, eHealth Ontario, OntarioMD and the EMR vendor. The e-Prescribing pilot project has been utilized by eHealth Ontario to develop "lessons learned" in support of the Medication Management strategy and implementation of the Drug Information System of Ontario in 2013.

Engaging the Community

In 2011-2012, the activities of the North Simcoe Muskoka LHIN continued to be supported by the commitment, knowledge and passion of hundreds of local individuals participating on our councils and steering committees, networks and project teams.

Our annual *Care Connections* forum was held in June 2011 and saw 320 individuals engaged in working sessions, related to the implementation of the initial areas of focus.

In addition, presentations were made by the Board Chair and CEO to almost all North Simcoe Muskoka municipal and district councils.

A record of community engagement activities can be seen by clicking on the *Engaging our Communities* page on the North Simcoe Muskoka LHIN website.

Aboriginal and Francophone Engagement

The North Simcoe Muskoka LHIN Leadership Council provided strategic advice on the development of the integrated health system design. Council members are representative of the entire health system, including service providers funded by the LHIN and non-LHIN funded health related partners such as physicians, public health and municipalities. The Aboriginal and francophone communities are represented on the Council.

Francophone Engagement

A French Language Services Provincial Working Group was established to:

- Develop a FLS accountability framework for LHINs and health service providers, including planning and reporting requirements and tools.
- Share FLS best practices and develop FLS key performance measures.
- Recommend strategies and processes to guide the work of the LHINs.
- Develop a framework to address complaints relating to the local health systems.
- Provide input into a common reporting format for francophone community engagement activities.
- Working groups have been established to work on specific policies and procedures regarding French Language Service implementation and integration.

The North Simcoe Muskoka, Central East and Central LHINs have established a working group and meet regularly with the Entité de planification pour les services de santé en français #4 Centre Sud-Ouest / French language health planning entity #4 for Central South West Ontario. French Language Planning Entity 4 is in the process of developing work plans to assist the three LHINs with their francophone community engagement activities.

Francophone engagement for North Simcoe Muskoka is being coordinated by the FLPE#4 which has a specific mandate of engaging the local Francophone community. A first community engagement session was held at La Clé d'la Baie, the Francophone community cultural centre.

Aboriginal Engagement

The NSM LHIN renewed its Project Funding Agreement with the Aboriginal Health Circle which is hosted by the Barrie and Area Native Advisory Circle. The objective of the AHC – Aboriginal Advisory Circle to provide expertise on North Simcoe Muskoka's Aboriginal population, current assessment, future development areas and partnership opportunities to meet the deliverables of the LHIN's strategic priorities (i.e. with the Aboriginal Health Circle, the respective staff of the Circle, involvement with and participation in the *Care Connections* Project, consulting and working with LHIN geographic, diabetes and ER/ALC priority leads).

An Aboriginal Health Symposium was held on March21, 2012 which brought together a cross section of the North Simcoe Muskoka Aboriginal community. Highlights included the honoring of the Eagle Staffs, Putting our Health Care Priorities into Action, information-sharing and workshops.

Performance

Table 1: Ministry-LHIN Performance Agreement – Performance Indicators for 2011-12

Performance Indicator	NSM 2011-12 Starting Point	NSM 2011-12 Performance Target	Most Recent Quarter 2011-12 NSM Performance	Percent from Target for Most Recent Quarter Result*	NSM 2011-12 Annual Result
EMERGENCY ROOM / ALTERNATE LEVEL OF CARE					
1. Percentage of Alternate Level of Care (ALC) Days - By LHIN or Institution***	19.40%	15.40%	21.82%	41.7%	19.21%
2. 90th Percentile ER Length of Stay for Admitted Patients	23.23	23.00	26.58	15.6%	24.77
3. 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS 1-3) Patients	6.90	6.80	6.72	-1.2%	6.55
4. 90th Percentile ER Length of Stay for Non-Admitted Minor Non-Complicated (CTAS 4-5) Patients	4.00	4.00	3.85	-3.8%	3.90
SURGICAL WAIT TIMES					
5. 90th Percentile Wait Times for Cancer Surgery	61	55	65	18.2%	62
6. 90th Percentile Wait Times for Cardiac By-Pass Procedures	Not applicable for North Simcoe Muskoka				
7. 90th Percentile Wait Times for Cataract Surgery	133	133	130	-2.3%	157
8. 90th Percentile Wait Times for Hip Replacement	243	182	145	-20.3%	146
9. 90th Percentile Wait Times for Knee Replacement	235	182	127	-30.2%	138
DIAGNOSTIC WAIT TIMES					
10. 90th Percentile Wait Times for Diagnostic MRI Scan	105	90	107	18.9%	113
11. 90th Percentile Wait Times for Diagnostic CT Scan	30	28	32	14.3%	28
EXCELLENT CARE FOR ALL / QUALITY					
12. Readmission within 30 Days for Selected Case Management Groups**	15.53%	14.20%	15.47%	8.9%	15.06%

Performance Indicator	NSM 2011-12 Starting Point	NSM 2011-12 Performance Target	Most Recent Quarter 2011-12 NSM Performance	Percent from Target for Most Recent Quarter Result*	NSM 2011-12 Annual Result
MENTAL HEALTH AND SUBSTANCE ABUSE					
13. Repeat Unplanned ER visits within 30 Days for Mental Health Conditions**	13.60%	13.60%	15.12%	11.2%	14.03%
14. Repeat Unplanned ER Visits within 30 Days for Substance Abuse Conditions**	15.60%	14.00%	14.18%	1.3%	16.86%
ACCESS TO COMMUNITY CARE					
15. 90th Percentile Wait Time from Community for CCAC In-Home Services – Application from Community Setting to first CCAC Services (excluding case management)	75.00	67.50	63.00	-6.7%	64.00

Source: Ministry of Health and Long-Term Care

* A negative percentage means North Simcoe Muskoka has met its target

** 2011-12 is based on the most recent 4 quarters of data (Q3 2010-11 - Q2 2011-12) due to availability

*** 2011-12 is based on the most recent 4 quarters of data (Q4 2010-11 to Q3 2011-12) due to availability

Ministry-LHIN Performance Agreement

The North Simcoe Muskoka Local Health Integration Network (NSM LHIN) and the Ministry of Health and Long-Term Care (MOHLTC) negotiated and signed a performance agreement which defines the obligations and responsibilities of both the LHIN and the ministry for 2011-2012. The Ministry/LHIN Performance Agreement (MLPA) includes a number of schedules which outline expectations of the LHIN regarding Community Engagement; Planning and Integration; Local Health System Management; Financial Management; Local Health System Performance and Reporting. The MLPA is mirrored in the Accountability Agreements that LHINs have now negotiated with all health service providers.

Performance Indicators for 2011-12 - Notes

1. **Percentage of Alternate Level of Care (ALC) Days**
   NSM LHIN continues to struggle in decreasing its overall percentage of ALC days. Despite a significant decrease of 2.61% (the largest drop across the LHINs in the province), at 19.21%, NSM LHIN ranks 13th overall in the province. By year-end, NSM LHIN managed to improve overall performance in this indicator slightly from the 2011-12 starting point of 19.40%. While the NSM percentage of ALC days continues to be higher than the provincial average of 15.63%, NSM LHIN in Q3 2011-12 had the fourth lowest number of long stay ALC patients occupying both acute and post acute care beds in their catchment area. The ALC days associated with these "long-stay ALC" cases are not included in the percentage ALC days calculation; they will only be included when these patients are discharged.

2. **90th Percentile ER Length of Stay for Admitted Patients**
   Although the 90th percentile ER length of stay (LOS) for admitted patients at year end was greater than at the start of 2011-12 (with an annual LOS of 24.77 hours), the NSM LHIN ranked 2nd best in the province overall in this metric. The annual result is above the LHIN target of 23 hours but remains below the provincial target of 25 hours and more than 6.3 hours less than the provincial average of 31.1 hrs prior to admission. NSM LHIN's decline in performance is largely attributable to infection control issues at two hospitals during Q3. Efforts undertaken in NSM LHIN hospitals to reduce ER LOS for admitted patients over the past year include the addition of Patient Navigators and Resource Nurses on in-patient units (and the ER) to improve patient flow and reduce avoidable admissions.

3. **90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS 1-3) Patients**
   The 90th percentile ER length of stay (LOS) for non-admitted complex patients at year end improved from the previous quarter by 1.2%, now at 6.55 hours, remaining below the LHIN baseline of 6.9 hours and the provincial average of 7.25 hours. Now ranked third best in the province, the 90th percentile LOS has improved overall in the LHIN by a further 10 minutes from third quarter performance. When compared to the provincial average, complex patients in NSM LHIN now leave the Emergency Departments of their hospitals generally 42 minutes sooner than the provincial average. The utilization of Clinical Decision Units (CDUs), reduced time to physician

initial assessment, improvements in registration, triage, assessment, bed management, improved availability of diagnostic results and the addition of ER Patient Navigators have all played a role in improved outcomes and decreased ER LOS. At Collingwood General and Marine Hospital, implementation of a 'See and Treat' program has contributed to a better flow of non-urgent patients through the department.

4. **90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS 4-5) Patients**
   The 90th percentile ER length of stay (LOS) for non-admitted minor uncomplicated patients declined by 3 minutes at year end as compared to Q3 performance (from 3.85 to 3.90 hours), still below the provincial target of 4.0 hours. Now ranked 5th best in the province, this positive performance is attributable to successful patient flow interventions. Overall, NSM LHIN remains below the provincial average of 4.27 hours, representing a positive 22 minute variance in ER LOS for minor uncomplicated patients.

5. **90th Percentile Wait Times for Cancer Surgery**
   Wait times for cancer surgery in the NSM LHIN for 2011-12 were 62 days, above the target of 55 days. Oncology services are provided at five NSM hospitals, the majority of which are performed at Royal Victoria Regional Health Centre (RVH). Although RVH has been expanding its facilities and services to meet the demands of the population, the wait times kept increasing during 2011-12 and it is expected that demands for cancer surgeries will grow in 2012-13.

6. **90th Percentile Wait Times for Cardiac Bypass Surgery**
   Cardiac bypass surgery is not performed in the North Simcoe Muskoka LHIN hospitals.

7. **90th Percentile Wait Times for Cataract Surgery**
   Wait times for cataract surgery in NSM LHIN were 157 days for 2011-12, above the target of 133 days. During 2011-12, Orillia Soldiers' Memorial Hospital (OSMH) experienced scheduling constraints in the provision of operating room hours for cataract services. This resulted in high wait times throughout the year for cataract surgeries, both at the hospital and the LHIN level; OSMH is one of three NSM hospitals performing cataract surgeries. In the fourth quarter of 2011-12, wait times in the LHIN decreased from 164 to 130 days. This was a result of increased access for surgeons to the OSMH operating room and from additional cataract funding provided to the other two NSM hospitals in the fourth quarter of 2011-12.

8. **90th Percentile Wait Times for Hip Replacement**
   In 2011-12 North Simcoe Muskoka LHIN wait times for hip replacement surgery were 146 days and 138 days for knee replacement surgery, below the target of 182 days for both hip surgery and knee surgery. The improvement in wait times is associated with the on-going dialogue happening in the NSM LHIN under the *Care Connections* Surgery Coordinating Council which has brought together hospitals and orthopaedic surgeons, community partners and the Bone and Joint Health Network of Ontario.

9. **90% Percentile Wait Times for Knee Replacement**
   Same as #8.

10. **90th Percentile Wait Times for Diagnostic MRI**
    Wait times for MRI exams in NSM LHIN was 113 days in 2011-12, above the target of 90 days. The NSM LHIN had the second highest wait times for MRI exams in the province. Royal Victoria Regional Health Centre (RVH) and Orillia Soldiers' Memorial Hospital are the only NSM hospitals with MRI machines – one at each location. It is expected that MRI wait times will continue to rise until the second MRI machine at RVH becomes operational in 2012-13.

11. **90th Percentile Wait Times for Diagnostic CT Scan**
    The wait time for CT scans in NSM LHIN was at the 28 days target for 2011-12. RVH is the biggest hospital in NSM and has been facing increasing demands on all its services, including the diagnostic imaging department. This is reflected in the increased wait times in the fourth quarter of 2011-12 from 28 days to 32 days, ranking the NSM LHIN fifth worst performing LHIN in the province.

12. **Readmission within 30 Days for Selected Case Management Groups**
    The readmission rate within 30 days for selected Case Management Groups (CMG) in NSM LHIN was 15.06% in 2011-12. This rate is an improvement from the NSM LHIN baseline of 15.53%, but still remains higher than the target of 14.20%. Both the LHIN and the hospitals are working with the NSM Integrated Vascular Steering Committee to better understand the hospital readmissions that are occurring.

13. **Repeat Unplanned ER Visits within 30 Days for Mental Health Conditions**
    The rate of repeat unscheduled emergency visits within 30 days for mental health conditions in the NSM LHIN was 14.03% in 2011-12. This rate is above the target of 13.60%. Performance has fluctuated across the quarters and according to the most recent quarterly result (Q2 2011-12), the rate rose from 13.98% to 15.12%. Even then, NSM LHIN remains the lowest rate in the province.
    The rate of repeat unscheduled emergency visits within 30 days for substance abuse conditions in the NSM LHIN was 16.86% in 2011-12. This rate is above the target of 14.00%. Performance has fluctuated across the quarters and according to the most recent quarterly result (Q2 2011-12), the rate dropped from 18.29% to 14.18%, by far the lowest rate in the province.
    Mental Health and Addiction (MHA) is one of the lead areas of focus in the NSM LHIN *Care Connections* initiative (10-year integrated health system plan). The MHA agenda is being discussed through a regionally coordinated approach under the leadership of the Mental Health and Addictions Coordinating Council. The MHA Coordinating Council, led by the CEO of Waypoint Centre for Mental Health Care, is overseeing three distinct initiatives namely, the transfer of Waypoint Schedule 1 acute adult mental health beds to community hospitals, building child and adolescent capacity and community crisis management.

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Financial statements of

North Simcoe Muskoka Local Health Integration Network

March 31, 2012

North Simcoe Muskoka Local Health Integration Network

March 31, 2012

Table of contents

Independent Auditor's Report 1-2

Statement of financial position 3

Statement of financial activities 4

Statement of changes in net debt 5

Statement of cash flows 6

Notes to the financial statements 7-19

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Independent Auditor's Report

To the Members of the Board of Directors of the
North Simcoe Muskoka Local Health Integration Network

We have audited the accompanying financial statements of the North Simcoe Muskoka Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2012, and the statements of financial activities, changes in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of North Simcoe Muskoka LHIN as at March 31, 2012, and the results of its financial activities, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 28, 2012

North Simcoe Muskoka Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**1,290,161**	683,181
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding Health Service Provider ("HSP") transfer payments	**264,800**	2,876,506
HST receivable	**135,703**	98,141
Due from LHIN Shared Services Office (Note 4)	**7,500**	-
	1,698,164	3,657,828
Liabilities		
Accounts payable and accrued liabilities	**1,079,374**	645,108
Due to MOHLTC/e-Health Ontario (Note 3b)	**344,942**	68,382
Due to HSPs	**264,800**	2,876,506
Due to the LHIN Shared Services Office and LHIN Collaborative (Note 4)	**-**	36,779
Deferred revenue	**24,022**	31,053
Deferred capital contributions (Note 5)	**182,551**	190,392
	1,895,689	3,848,220
Commitments (Note 6)		
Net debt	**(197,525)**	(190,392)
Non-financial assets		
Prepaid expenses	**14,974**	-
Capital assets (Note 7)	**182,551**	190,392
Accumulated surplus	**-**	-

Approved by the Board

Chair

Vice-Chair

North Simcoe Muskoka Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (Unaudited - Note 8)	2012 Actual	2011 Actual
	$	$	$
Revenue			
MOHLTC/e-Health Ontario funding			
HSP transfer payments (Note 9)	**726,114,053**	**782,876,927**	736,024,967
HSP capital payments (Note 10)	-	-	1,757,249
Operations of LHIN	**4,370,155**	**4,301,188**	4,306,193
LHIN Operations Special Funding (Note 11)	**3,359,514**	**2,908,814**	1,765,084
Amortization of deferred capital contributions (Note 5)	-	**76,807**	84,036
	733,843,722	**790,163,736**	743,937,529
Funding repayable to the MOHLTC/e-Health Ontario (Note 3a)	-	**(344,942)**	(205,600)
	733,843,722	**789,818,794**	743,731,929
Expenses			
Transfer payments to HSPs (Note 9)	**726,114,053**	**782,876,927**	736,024,967
Capital payments to HSPs (Note 10)	-	-	1,757,249
General operating expenses (Note 12)	**4,370,155**	**4,376,785**	4,367,337
LHIN Operations Special Funded Initiatives (Note 11)	**3,359,514**	**2,565,082**	1,582,376
	733,843,722	**789,818,794**	743,731,929
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

North Simcoe Muskoka Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	Budget (Unaudited - Note 8)	2012 Actual	2011 Actual
	$	$	$
Annual surplus	-	-	-
Acquisition of capital assets	-	**(68,966)**	(63,963)
Amortization of capital assets	-	**76,807**	84,036
Change in other non-financial assets	-	**(14,974)**	-
(Increase) decrease in net debt	-	**(7,133)**	20,073
Opening net debt	-	**(190,392)**	(210,465)
Closing net debt	-	**(197,525)**	(190,392)

North Simcoe Muskoka Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**76,807**	84,036
Amortization of deferred capital contributions (Note 5)	**(76,807)**	(84,036)
	-	-
Changes in non-cash operating items		
Increase in prepaid expenses	**(14,974)**	-
Decrease (increase) in due from MOHLTC ("HSP's")	**2,611,706**	(2,125,472)
(Increase) decrease in due from LHIN Shared Services Office	**(7,500)**	11,964
Increase in HST receivable	**(37,562)**	(98,141)
Increase (decrease) in accounts payable and accrued liabilities	**434,266**	(353,293)
Increase in due to the MOHLTC / e-Health Ontario	**276,560**	19,219
(Decrease) increase in due to HSPs	**(2,611,706)**	2,312,472
(Decrease) increase in due to the LHIN Shared Services Office and LHIN Collaborative Office	**(36,779)**	36,641
Decrease in deferred revenue	**(7,031)**	(32,804)
	606,980	(229,414)
Capital Investment		
Acquisition of capital assets	**(68,966)**	(63,963)
Financing transactions		
Capital contributions received (Note 5)	**68,966**	63,963
Net increase (decrease) in cash	**606,980**	(229,414)
Cash, beginning of year	**683,181**	912,595
Cash, end of year	**1,290,161**	683,181

1. Description of business

The North Simcoe Muskoka Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the North Simcoe Muskoka Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the municipalities of Muskoka, most of Simcoe County and part of Grey County. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers ("HSP") in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2012.

The LHIN statements do not include any MOHLTC managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario – LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets, and losses in the value of assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and the reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund capital asset purchases, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment and development	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and equipment	5 years straight-line method

For assets acquired or bought into use during the year, amortization is provided for a full year.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Segmented disclosures

Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

3. Funding repayable to the MOHLTC/eHealth Ontario

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the eHealth Ontario.

a. The amount repayable to the MOHLTC/eHealth Ontario related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2012 Excess Funding	2011 Excess Funding
	$	$	$	$
LHIN operations	4,377,995	4,376,785	1,210	22,892
Aboriginal Planning	30,000	30,000	-	-
Behavioural Supports Ontario, Coordination and Reporting Office	500,000	419,218	80,782	-
Behavioural Supports Ontario, Service Redesign	750,000	583,727	166,273	-
Critical Care Lead	75,000	73,695	1,305	2,250
e-Health Project Management Office	600,000	576,148	23,852	10,505
Emergency Department LHIN Lead	75,000	75,000	-	3,845
Entite de planification des services de sante en francais #4 Centre Sud-Ouest	654,064	586,233	67,831	-
Emergency Room/Alternative Level of Care Performance Lead	100,000	100,000	-	-
Francophone Community Engagement	-	-	-	43,217
French Language Health Services	106,000	102,311	3,689	13,280
Ontario LHINs Privacy Project	-	-	-	100,473
Primary Care LHIN Lead	18,750	18,750	-	-
www.ufirst.ca - Physician and Specialist eReferral System	-	-	-	9,138
	7,286,809	6,941,867	344,942	205,600

b. The amount due to the MOHLTC/eHealth Ontario at March 31 is made up as follows:

	2012	2011
	$	$
Due to MOHLTC, beginning of year	68,382	49,163
Funding repaid to MOHLTC during the current year	(68,382)	(186,381)
Funding repayable to the MOHLTC/eHealth Ontario related to current year activities (Note 3a)	344,942	205,600
Due to MOHLTC/eHealth Ontario, end of year	344,942	68,382

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs, is responsible for providing services to all LHINs. The full costs of providing these services are billed to all of the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

LHIN Collaborative (LHINC) was formed in fiscal 2010 as a LHIN-led service to strengthen relationships between and among health service providers. LHINC is accountable to the LHINs, and funded by the LHINs with support from the Ministry of Health and Long-Term Care.

5. Deferred capital contributions

	2012	2011
	$	$
Balance, beginning of year	**190,392**	210,465
Capital contributions received during the year	**68,966**	63,963
Amortization for the year	**(76,807)**	(84,036)
Balance, end of year	**182,551**	190,392

6. Commitments

The LHIN has commitments under various operating leases expiring at dates up to 2015 related to building and equipment. Lease renewals are likely. Minimum lease payments due over the remaining terms of these leases are as follows:

	$
2013	182,659
2014	179,694
2015	179,694

6. Commitments (continued)

The LHIN also has funding commitments to certain HSPs associated with accountability agreements. Minimum annual commitments to HSPs for fiscal 2013, based on the current accountability agreements are as follows:

	$
Operation of hospitals	**370,073,503**
Grants to compensate for municipal taxation - public hospitals	**77,625**
Long term care homes	**120,837,244**
Community care access centres	**74,272,517**
Community support services	**11,526,135**
Assisted living services in supportive housing	**5,950,678**
Community health centres	**8,737,760**
Community mental health	**22,668,261**
Addictions program	**3,969,783**
Specialty psychiatric hospitals	**103,775,200**
Grants to compensate for municipal taxation - psychiatric hospitals	**23,400**
Acquired brain injury	**1,145,214**
	723,057,320

The actual amounts which will ultimately be paid are contingent upon LHIN funding received by the MOHLTC.

7. Capital assets

			2012	2011
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and equipment	**488,361**	**368,658**	**119,703**	137,982
Computer equipment	**151,240**	**145,415**	**5,825**	13,210
Leasehold improvements	**969,056**	**912,033**	**57,023**	39,200
	1,608,657	**1,426,106**	**182,551**	190,392

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2011. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $782,887,033 is made up of the following:

	$
Initial budget	**726,114,053**
Adjustment due to announcements made during the year	**56,772,980**
	782,887,033

8. Budget figures (continued)

The total revised operating budget of $7,278,969 is made up of the following:

	$
Initial operating budget as reported on the statement of financial activities	**7,729,669**
Adjust for funding changes made during the year:	
eHealth - Ontario LHINs Privacy Project	**(217,000)**
Primary Care LHIN Lead	**(25,000)**
Behavioural Support Services	**(150,000)**
ALC Recource Matching and Referal Business Transformation Initiative	**(58,700)**
Revised operating budget	**7,278,969**

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $782,876,927 (2011 - $736,024,967) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2012 as follows:

	2012	2011
	$	$
Operation of hospitals	**410,003,430**	384,229,083
Grants to compensate for municipal taxation - public hospitals	**77,625**	77,625
Long term care homes	**127,716,175**	118,110,631
Community care access centres	**82,889,476**	76,378,367
Community support services	**12,737,994**	12,081,422
Assisted living services in supportive housing	**6,073,700**	5,668,756
Community health centres	**8,979,736**	7,587,106
Community mental health	**23,293,380**	22,594,107
Addictions program	**4,084,914**	3,910,662
Specialty psychiatric hospitals	**105,859,683**	104,218,594
Grants to compensate for municipal taxation - psychiatric hospitals	**23,400**	23,400
Acquired brain injury	**1,137,414**	1,145,214
	782,876,927	736,024,967

10. Capital payments to HSPs

The 2010/11 allocation represents the approved LHIN allocation to support grants for public and specialty psychiatric hospitals in 2010/11 under the 2010/11 Health Infrastructure Renewal Fund (HIRF), and in accordance with 2010/11 HIRF Guidelines which the ministry has provided to LHINs.

In 2011/12, HIRF grants were allocated as Ministry managed funds.

11. LHIN operations special funding

The LHIN received operational funding for special initiatives during the year as follows:

	2012	2011
	$	$
Aboriginal Planning	**30,000**	30,000
Behavioural Supports Ontario Coordination and Reporting Office	**500,000**	-
Behavioural Supports Ontario Service Redesign	**750,000**	-
Behavioural Support Systems	**-**	75,000
Critical Care LHIN Lead	**75,000**	75,000
e-Health Project Management Office	**600,000**	600,000
Emergency Department LHIN Lead	**75,000**	75,000
Emergency Room/Alternate Level of Care Performance Lead	**100,000**	100,000
Entite de planification des services de sante en francais #4 Centre Sud-Ouest	**654,064**	201,557
Francophone Community Engagement	**-**	63,857
French Language Health Services	**106,000**	74,670
Information & Community Technology - e-Health Framework	**-**	220,000
Ontario LHINs Privacy Project	**-**	166,000
Primary Care LHIN Lead	**18,750**	-
www.ufirst.ca - Physician and Specialist eReferral System	**-**	84,000
	2,908,814	1,765,084

a) *Aboriginal Planning*

The LHIN received funding of $30,000 (2011 - $30,000) related to the Aboriginal Planning initiative. Aboriginal Planning expenses incurred during the year are as follows:

	2012	2011
	$	$
Special project expenditures	**30,000**	30,000

11. LHIN operations special funding (continued)

b) Behavioural Supports Ontario, Coordination and Reporting Office

The LHIN received funding of $500,000 (2011 - $Nil) related to Behavioural Supports Ontario, Coordination and Reporting Office. Expenses incurred during the year for this initiative are as follows:

	2012	2011
	$	$
Salaries and benefits	223,553	-
Occupancy	8,782	-
Advertising and public relations	25,005	-
Consulting services	80,000	
Other services	37,092	-
Supplies, equipment and licences	21,890	-
Travel	10,377	-
Mail, courier and telecommunications	12,519	-
	419,218	-

c) Behavioural Supports Ontario, Service Redesign

The LHIN received funding of $750,000 (2011 - $Nil) related to Behavioural Supports Ontario, Service Redesign. Expenses incurred during the year for this initiative are as follows:

	2012	2011
	$	$
Salaries and benefits	225,164	-
Occupancy	8,121	
Advertising and public relations	20,471	
Consulting services	193,255	
Other services	72,329	
Supplies, equipment and licences	47,674	-
Travel	14,911	
Mail, courier and telecommunications	1,802	-
	583,727	-

d) Critical Care LHIN Lead

The LHIN received funding of $75,000 (2011 - $75,000) related to the Critical Care Lead initiative. Critical Care Lead expenses incurred during the year are as follows:

	2012	2011
	$	$
Consulting services	73,695	72,750

11. LHIN operations special funding (continued)

e) e-Health Project Management Office

The LHIN received funding of $600,000 (2011 - $600,000) related to the e-Health Project Management Office initiative. E-Health expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries and benefits	**440,333**	436,360
Occupancy	**15,998**	26,102
Shared services	**37,502**	47,933
Consulting services	**19,679**	14,640
Other services	**27,445**	14,108
Supplies, equipment and licences	**21,466**	35,026
Travel	**5,965**	7,644
Mail, courier and telecommunications	**7,760**	7,682
	576,148	589,495

f) Emergency Department LHIN Lead

The LHIN received funding of $75,000 (2011 - $75,000) related to the Emergency Department Lead initiative. Emergency Department Lead expenses incurred during the year are as follows:

	2012	2011
	$	$
Consulting services	**75,000**	71,155

g) Emergency Room/Alternate Level of Care Performance Lead

The LHIN received funding of $100,000 (2011 - $100,000) related to the Emergency Room/Alternate Level of Care Performance Lead initiative. Expenses incurred during the year for this project are as follows:

	2012	2011
	$	$
Salaries and benefits	**100,000**	97,877
Other services	**-**	730
Travel	**-**	642
Mail, courier and telecommunications	**-**	751
	100,000	100,000

11. LHIN operations special funding (continued)

h) Entite de planification des services de sante en francais #4 Centre Sud-Ouest

The LHIN received funding of $654,064 (2011 - $201,557) related to the Entite de planification des services de sante en francais #4 Centre Sud-Ouest. Expenses incurred during the year for this initiative are as follows:

	2012	2011
	$	$
Special project expenditures	**586,233**	201,557

i) Francophone Community Engagement

The LHIN received funding of $Nil (2011 - $63,857) related to Francophone Community Engagement. Expenses incurred during the year for this initiative are as follows:

	2012	2011
	$	$
Salaries and benefits	-	14,347
Other services	-	6,293
	-	20,640

j) French Language Health Services

The LHIN received funding of $106,000 (2011 - $74,670) related to French Language Health Services. Expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries and benefits	**87,150**	56,989
Occupancy	**5,333**	-
Other services	**2,542**	139
Supplies, equipment and licences	**1,620**	2,898
Travel	**4,630**	984
Mail, courier and telecommunications	**1,036**	380
	102,311	61,390

11. LHIN operations special funding (continued)

k) Information and Community Technology - e-Health Framework

The LHIN received funding of $Nil (2011 - $220,000) related to the Information and Community Technology - e-Health Framework Project. Expenses incurred during the year for this project are as follows:

	2012	2011
	$	$
Consulting services	-	220,000

l) Ontario LHINs Privacy Project

The LHIN received funding of $Nil (2011 - $166,000) related to the e-Health Ontario LHINs Privacy Project. Expenses incurred during the year for this project are as follows:

	2012	2011
	$	$
Consulting services	-	65,527

m) Primary Care LHIN Lead

The LHIN received funding of $18,750 (2011 - $Nil) related to the Primary Care LHIN Lead. Expenses incurred during the year for this strategy are as follows:

	2012	2011
	$	$
Consulting Services	18,750	-

n) www.ufirst.ca - Physician and Specialist eReferral System

The LHIN received funding of $Nil (2011 - $84,000) related to the www.ufirst.cc - Physician and Specialist eReferral System Project. Expenses incurred during the year for this project are as follows:

	2012	2011
	$	$
Consulting services	-	74,862

12. General operating expenses

The Statement of Financial Activities presents the expenses by function, the following classifies general operating expenses, by object:

	2012	2011
	$	$
Salaries and benefits	**2,792,133**	2,921,819
Occupancy	**127,826**	169,660
Amortization	**76,807**	84,036
Shared services	**464,493**	394,562
Advertising and public relations	**3,007**	7,676
Consulting services	**99,200**	287,225
Other services	**495,112**	223,799
Supplies, equipment and licences	**82,494**	63,873
Board expenses	**143,526**	119,634
Travel	**41,077**	48,833
Mail, courier and telecommunications	**51,110**	46,220
	4,376,785	4,367,337

Board expenses included in general operating expenses above include per diem costs and other Board expenses as follows:

	Budget	2012 Actual	2011 Actual
	$	$	$
Board Chair per diem cost	**50,400**	**55,825**	54,600
Directors per diem cost	**62,400**	**55,325**	40,600
Board expenses	**35,000**	**32,376**	24,434
	147,800	**143,526**	119,634

13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 26 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $269,099 (2011 - $258,386) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2011. At that time, the plan was fully funded.

14. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

15. Comparative figures

Certain comparative figures have been reclassified to conform to the current year presentation.

14. **Repeat Unplanned ER Visits within 30 Days for Substance Abuse Conditions**
Same as #13.

15. **90th Percentile Wait time from Community for CCAC In-Home Services – Application from Community Setting to First CCAC Services**
In North Simcoe Muskoka for 2011-12 the 90th percentile wait time from community for CCAC in-home services was 64 days - 11 lower than the baseline of 75 days and 6.7% better than the Ministry-LHIN Performance Agreement (MLPA) target of 67.5 days. Several initiatives underway in the LHIN, as well as new base funding for the NSM CCAC, contributed to the substantial drop in wait times from 98 days in Q1 to 63 days in Q4. With new base funding announced in December 2011, the NSM CCAC confirmed that very high priority clients were successfully moved off the personal support waiting list.

North Simcoe Muskoka LHIN Operations

The North Simcoe Muskoka LHIN managed an allocation of $7,278,969 in fiscal year 2011-12. The allocation is comprised of the LHIN's base operational budget of $4,370,155, and special initiative funding of $2,908,814.

The LHIN received special initiative funding to support provincial priorities as follows:

- Aboriginal Planning
- Behavioural Supports Ontario, Coordination and Reporting Office
- Behavioural Supports Ontario, Service Redesign
- Critical Care LHIN Lead
- Emergency Department LHIN Lead
- Emergency Room / Alternate Level of Care Performance Lead
- e-Health Project Management Office
- Entite de planification des services de santé en francais #4 Centre Sud-Ouest / French language Health Planning Entity #4 for Central South West Ontario
- French Language Health Services
- Primary Care LHIN Lead

Our Auditors' Report with audited financial statements and accompanying notes follow.